specialized, statutory teaching, rural, CHEP hospitals, or those hospitals included in Section V. A. 10 and 11 of the Plan. An inpatient fixed cost reimbursement ceiling shall be established for all hospitals except rural hospitals and specialized psychiatric hospitals. Out-of-state hospitals shall be considered to be general hospitals under this plan.

C. Reimbursement ceilings shall be established prospectively for each Florida County. Beginning with the July 1, 1991, rate period, additional ceilings based on the target rate system shall be imposed. The target rate ceiling shall be the approved rate of increase in the prospective payment system for the Medicare Inpatient Hospital Reimbursement Program as determined by the Department of HHS. For fiscal year 1991-1992, the allowable rate of increase shall be 3.3 percent. Effective July 1, 1995, the target rate ceiling shall be calculated from an annually adjusted Data Resource Inc. (DRI) inflation factor. The DRI inflation factor for this time period is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. These target ceilings shall apply to inpatient variable cost per diems (facility specific target ceilings) and county ceilings (county target ceilings) and shall be used to limit per diem increases during state fiscal years. The facility specific target and county target ceilings shall apply to all general hospitals. Rural, specialized, statutory teaching, Community Hospital Education Program (CHEP)

hospitals, and those hospitals included in Section V. A. 10 and 11 of the Plan are exempt from both target ceilings.

D. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods the reimbursement ceilings shall be effective from January 1 through June 30 and July 1 through December 31 of the appropriate years except as provided in H. below. Inpatient reimbursement ceilings set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003.

E. Changes in individual hospital per diem rates shall be effective from July 1 through December 31 and January 1 through June 30 of each year. Inpatient reimbursement rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003.

F. For the initial period, the last cost report received from each hospital as of March 31, 1990 shall be used to establish the reimbursement ceilings. For subsequent periods, all cost reports postmarked by March 31 and September 30 and received by AHCA by April 15 and October 15 respectively shall be used to establish the reimbursement ceilings. For the initial period within 20 days after publication, a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the proposed reimbursement ceilings. Subsequent rate periods shall not be automatically subject to public hearing.

G. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings.

H. The prospectively determined individual hospital's rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.

2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond 3 years of the effective date that the rate was established, or if the change is not material.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

   Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

4. The charge structure of a hospital changes and invalidates the application of the lower of cost or charges limitations.

I. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with 59-1.018, F.A.C., and Section 120.57, Florida Statutes.

J. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling, except as provided for in Sections IV.B and C.

K. The agency shall distribute monies as appropriated to hospitals providing a disproportionate share of Medicaid or charity care services by increasing Medicaid payments to hospitals as required by Section 1923 of the Act.

L. The agency shall distribute monies as appropriated to hospitals determined to be disproportionate share providers by allowing for an outlier adjustment in Medicaid payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age as required by Section 1923 of the Act.

V. Methods

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings for Inpatient Variable Cost.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:

   a. To reflect the results of desk audits;

   b. To exclude from the allowable costs, any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 .

3. Determine allowable Medicaid variable costs defined in Section X of this plan.

4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30, or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of March 31 or

September 30 for the Data Resources Incorporated (DRI) National and Regional Hospital Input Price Indices as detailed in Appendix A.

5. Divide the inflated allowable Medicaid variable costs by the latest available health care component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.

6. Divide the results of Step 5 for each hospital by the sum of its Medicaid regular inpatient days plus Medicaid non-concurrent nursery days resulting in a variable cost per diem rate. Medicaid non-concurrent nursery days are inpatient nursery days for a Medicaid eligible newborn whose mother is not an inpatient in the same hospital at the same time.

7. Array the per diem rates in Step 6 from the lowest to the highest rate for all general hospitals within the State with the associated Medicaid patient days.

8. For general hospitals in a county, set the county ceiling for variable costs at the lower of:

   a. The cost based county ceiling which is the per diem rate associated with the 70th percentile of Medicaid days from Step 7 times the FPLI component utilized in Step 5 for the county;

   b. The target county ceiling that is the prior January rate semester's county ceiling plus an annually adjusted factor using the DRI inflation table. Effective July 1, 1995, the DRI inflation factor is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase

shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year.

9. Specialized, statutory teaching, and rural hospitals are excluded from the calculation and application of the reimbursement county ceilings in V.A.1 through 8., above. Community Hospital Education Program (CHEP) hospitals and those hospitals included in 10 and 11 below are included in the calculation of the ceilings in V.A. 1 through 8, above, but are exempt from the application of these ceilings. For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

10. Effective July 1, 2001, inpatient reimbursement ceilings will be eliminated for hospitals whose sum of charity care and Medicaid days as a percentage of adjusted patient days equals or exceeds fifteen percent. Effective July 1, 2002, the fifteen percent (15%) will be changed to fourteen and one-half percent (14.5%). The Agency shall use the 1997 audited DSH data available as of March 1, 2001 in determining eligibility for these adjustments to ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the

inpatient ceilings for hospitals whose charity care and Medicaid days, as a percentage of total adjusted hospital days, equals or exceeds 11 percent. The Agency will use the average of the 1997, 1998 and 1999 audited DSH data available as of March 1, 2003. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1997, 1998 and 1999 that is available. For those hospitals with only one year of audited DSH data, the Agency shall eliminate the inpatient reimbursement ceilings for only those hospitals with 1999 audited DSH data. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003.

11. Effective July 1, 2001, inpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 9.6% and are a trauma center. The Agency shall use the 1997 audited DSH data available as of March 1, 2001 in determining eligibility for these adjustments to ceilings. Effective July 1, 2003, The Agency will use the average of the 1997, 1998 and 1999 audited DSH data available as of March 1, 2003. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1997, 1998 and 1999 that is available. Hospital inpatient rates set under the provisions of the Plan for the July 1, 2003 rate setting will be effective October 1, 2003.

B. Setting Reimbursement Ceilings for Fixed Cost

1. Compute the fixed costs per diem rate for each hospital by dividing the Medicaid depreciation by the total Medicaid days.

2. Calculate the fixed cost ceiling for each hospital by multiplying Step 1 by 80%. This fixed cost ceiling shall not apply to rural hospitals and specialized psychiatric hospitals.

C. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:

   a. To reflect the results of desk reviews or audits;

   b. To exclude from the allowable cost any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 .

3. Determine allowable Medicaid variable costs as in V.A.3.

4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the DRI National and Regional Hospital Input Price Index as detailed in Appendix A.

5. The variable cost per diem shall be the lessor of:

   a. The inflated allowable Medicaid variable costs divided by the sum of Medicaid inpatient days plus Medicaid non-concurrent nursery days for the hospital, or

b. The facility specific target ceiling that is the prior January's rate semester variable cost per diem plus an annually adjusted factor using the DRI inflation table. Effective July 1, 1995, the DRI inflation factor is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. The facility specific target ceiling shall apply to all hospitals except rural, specialized, statutory teaching, Community Hospital Education Program (CHEP) hospitals and those hospitals included in Section V.A. 10 and 11.

6. a. Establish the variable costs component of the per diem as the lower of the result of Step 5 or the reimbursement ceiling determined under V.A.8. for the county in which the hospital is located.

b. A temporary exemption from the county ceiling for a period not to exceed 12 months shall be granted to an in-state general hospital by AHCA if all of the following criteria are met:

(1) The hospital has been voluntarily disenrolled for a period of not less than 180 days in the 365 days immediately prior to the date of application for this exemption. The hospital shall have been a fully participating Medicaid provider prior to their last disenrollment;

(2) During the 6-month period prior to the last voluntary disenrollment, the hospital provided the largest proportionate share of Medicaid services of all hospitals in the county, as measured by total Medicaid costs for the period;

(3) On the date of the last voluntary disenrollment, less than 51 percent of the private, non-governmental hospitals in the county were participating in the Medicaid Program;

(4) During the 6-month period prior to the last voluntary disenrollment, the hospital treated over 50 percent of the indigent patients in the county who required hospital services during that time period. Indigent patients are those eligible for Medicaid or classified as indigent by a county-approved social services or welfare program.

If an exemption is granted to a hospital, the hospital shall agree to remain in the Medicaid Program and accept Medicaid eligible patients for a period of not less than 3 years from the date of re-enrollment. The exemption shall be granted to a hospital only once since original construction, regardless of changes in ownership or control. If a hospital

disenrolls prior to the fulfillment of its 3-year enrollment agreement, AHCA shall recoup funds paid to the hospital in excess of the amount that would have been paid if the county ceiling had been imposed during the first 12 months which shall be defined as excess amount, according to the following schedule. If a hospital is re-enrolled under the ceiling exemption provision for less than 12 months, the Agency shall recoup 100 percent of the excess amount. For each month of enrollment subsequent to the first year of re-enrollment under the ceiling exemption provision, 1/24 of the excess amount shall be no longer owed so that after 36 months of re enrollment AHCA shall recoup none of the excess amount. Example 1: Hospital reenrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on November 30, 1984. During this 5-month period the hospital receives an excess amount of $10,000. Recoupment would be calculated as:

$10,000 - ((0 months x 1/24) x (10,000)) =$10,000

Example 2: Hospital re-enrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on December 31, 1986. During the first 12 months the hospital receives an excess amount of $20,000. Recoupment would be calculated as:

$20,000 - ((18 months x 1/24) x (20,000)) = $ 5,000

7. Compute the fixed costs component of the per diem by dividing the Medicaid depreciation by the total Medicaid days.

8. Established the fixed costs component of the per diem as the lower of Step 7 or the reimbursement ceiling determined under V.B.2.